		FOR OHF USE					

LL1

2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0039651

Facility Name: Virgil Calvert Nursing and Rehabilitation Center

Address: 5050 Summit Ave. (Number) East St. Louis (City) 62202 (Zip Code)

County: St. Clair

Telephone Number: (618) 874-3597 **Fax #** (618) 874-1812

IDPA ID Number: 369523260001

Date of Initial License for Current Owners: 06/01/1994

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Charles J. Fischer **Telephone Number:** (312) 634-4580
Please send copies of desk review and audit adjustments to address on this page

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/04 to 12/31/04 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed)	(Date)
	(Type or Print Name)	
	(Title)	
Paid Preparer	(Signed)	SEE ACCOUNTANTS' COMPILATION REPORT (Date)
	(Print Name and Title)	
	(Firm Name & Address)	Altschuler, Melvoin and Glasser LLP One South Wacker Drive, Suite 800, Chicago, IL 60606
	(Telephone)	(312) 384-6000 Fax # (312) 634-5518

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Virgil Calvert Nursing and Rehabilitation Center # 0039651 Report Period Beginning: 01/01/04 Ending: 12/31/04

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	150	Skilled (SNF)	150	54,900	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	150	TOTALS	150	54,900	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	8,078	225	3,001	11,304	8
9	SNF/PED					9
10	ICF	28,231	60		28,291	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	36,309	285	3,001	39,595	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 72.12%

D. How many bed-hold days during this year were paid by Public Aid?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 06/01/1994

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 06/01/1994 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 27 and days of care provided 3,001

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/04 Fiscal Year: 12/31/04

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Virgil Calvert Nursing and Rehabilitation Ce # 0039651 Report Period Beginning: 01/01/04 Ending: 12/31/04

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	191,547	10,648	4,504	206,699		206,699		206,699			1
2	Food Purchase		163,238		163,238		163,238	(682)	162,556			2
3	Housekeeping	101,773	39,603		141,376		141,376	85	141,461			3
4	Laundry	92,297	16,418		108,715		108,715		108,715			4
5	Heat and Other Utilities			99,423	99,423		99,423	1,859	101,282			5
6	Maintenance	50,919	42,069	9,107	102,095		102,095	528	102,623			6
7	Other (specify):*											7
8	**TOTAL General Services**	436,536	271,976	113,034	821,546		821,546	1,790	823,336			8
	B. Health Care and Programs											
9	Medical Director			5,500	5,500		5,500		5,500			9
10	Nursing and Medical Records	1,170,385	22,429	6,640	1,199,454		1,199,454	(3,591)	1,195,863			10
10a	Therapy			298,513	298,513		298,513		298,513			10a
11	Activities	42,851	2,475		45,326		45,326		45,326			11
12	Social Services	27,131			27,131		27,131		27,131			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,240,367	24,904	310,653	1,575,924		1,575,924	(3,591)	1,572,333			16
	C. General Administration											
17	Administrative	59,735		243,250	302,985		302,985	(127,895)	175,090			17
18	Directors Fees											18
19	Professional Services			38,714	38,714		38,714	23,191	61,905			19
20	Dues, Fees, Subscriptions & Promotions			8,434	8,434		8,434	94	8,528			20
21	Clerical & General Office Expenses	96,355		26,081	122,436		122,436	70,295	192,731			21
22	Employee Benefits & Payroll Taxes			239,963	239,963		239,963	2,529	242,492			22
23	Inservice Training & Education											23
24	Travel and Seminar			445	445		445	78	523			24
25	Other Admin. Staff Transportation			5,906	5,906		5,906	265	6,171			25
26	Insurance-Prop.Liab.Malpractice			15,769	15,769		15,769	1,258	17,027			26
27	Other (specify):* Mgmt.Alloc.of Benefits							13,673	13,673			27
28	**TOTAL General Administration**	156,090		578,562	734,652		734,652	(16,512)	718,140			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,832,993	296,880	1,002,249	3,132,122		3,132,122	(18,313)	3,113,809			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Virgil Calvert Nursing and Rehabilitation Center #0039651 Report Period Beginning: 01/01/04 Ending: 12/31/04

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7**	8	9	10	
30	Depreciation			42,898	42,898		42,898	242,735	285,633			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			68,689	68,689		68,689	330,353	399,042			32
33	Real Estate Taxes							172,864	172,864			33
34	Rent-Facility & Grounds			720,000	720,000		720,000	(720,000)				34
35	Rent-Equipment & Vehicles			1,320	1,320		1,320	1,391	2,711			35
36	Other (specify):* Mortgage Insurance							29,819	29,819			36
37	**TOTAL Ownership**			832,907	832,907		832,907	57,162	890,069			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		60,443		60,443		60,443		60,443			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			82,350	82,350		82,350		82,350			42
43	Other (specify):* Nonallowable Costs			85,778	85,778		85,778	(85,778)				43
44	**TOTAL Special Cost Centers**		60,443	168,128	228,571		228,571	(85,778)	142,793			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,832,993	357,323	2,003,284	4,193,600		4,193,600	(46,929)	4,146,671			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

****See schedule of adjustments attached at end of cost report.**

SEE ACCOUNTANTS' COMPILATION REPORT

FOR LINES 1 THRU 28 AND 31 THRU 33, ENTER ONLY ONE LINE REFERENCE PER ROW. IF SIMILAR ADJUSTMENTS ARE MADE TO MORE THAN ONE LINE, ENTER THE ADDITIONAL ADJUSTMENTS ON LINES 29 OR 35 OF THIS SCHEDULE AND DETAIL THEM ON PAGE 5A.

Facility Name & ID Number Virgil Calvert Nursing and Rehabilitation Center # 0039651 Report Period Beginning: 01/01/04 Ending: 12/31/04

VI. ADJUSTMENT DETAIL **A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)**

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(20,775)	30		9
10	Interest and Other Investment Income	(68,813)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(327)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(78,596)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(2,218)	43		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Schedule 5A	(5,788)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (176,517)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	129,588		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 129,588		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (46,929)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Virgil Calvert Nursing and Rehabilitation Center
Provider #: 0039651
01/01/04 to 12/31/04 **Schedule 5A**

VI. Adjustment Detail
Line 29 - Other

Non-allowable expenses	Amount	Reference
Disallow Finance Charges	(353)	43
Disallow Part A Lab	(3,039)	43
Disallow Part A X-ray	(995)	43
Disallow Trust Fees	(250)	43
Offset Misc. Income	(1,151)	21
Total	**(5,788)**	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Virgil Calvert Nursing and Rehabilitation Center # 0039651 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached Schedule 6A		See Attached Schedule 6B		See Attached Schedule 6B		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	19	Professional Services	$	Virgil Calvert Property LLC	100.00%	$ 3,500	$ 3,500	1
2	V	21	Clerical & General Office Exp.		Virgil Calvert Property LLC	100.00%	724	724	2
3	V	36	Mortgage Insurance		Virgil Calvert Property LLC	100.00%	29,819	29,819	3
4	V	30	Depreciation		Virgil Calvert Property LLC	100.00%	259,961	259,961	4
5	V	32	Interest		Virgil Calvert Property LLC	100.00%	397,996	397,996	5
6	V	33	Real Estate Taxes		Virgil Calvert Property LLC	100.00%	168,955	168,955	6
7	V	34	Rent Facility & Grounds	720,000	Virgil Calvert Property LLC	100.00%		(720,000)	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 720,000			$ 860,955	$ * 140,955	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Virgil Calvert Nursing and Rehabilitation Center
Provider #: 0039651
12/31/04

Schedule 6B

VII Related Parties - Page 6

Related Nursing Homes	City
In-State:	
Cahokia Nursing and Rehab	Cahokia
Caseyville Nursing and Rehab	Caseyville
Franklin Grove Nursing Center	Franklin Grove
Kenwood Healthcare Center	Chicago
Oregon Healthcare Center	Oregon
Shabbona Healthcare Center	Shabbona
Tower Hill Healthcare Center	South Elgin
Virgil Calvert Nursing and Rehab	East St. Louis
Out-of-State:	
St. Elizabeth Healthcare Center	Florissant, MO

Other Related Business Entities		
S.W. Management Co.	Skokie	Bookkeeping/Management Company
S&E Medical Supply Co.	Skokie	Medical Supplies
* SFO Associates	Skokie	Finance Company
** Unity Hospice	Skokie	Hospice Services

* This entity only relates to Shabbona Healthcare Center, Franklin Grove Nursing Center, and Oregon Healthcare Center.

** Pages 6 and 8 are not required for this entity since there was no payment from the nursing homes to the related entity.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Virgil Calvert Nursing and Rehabilitation Center # 0039651 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	2	Food	$	S.W. Management Co.	100.00%	$ 45	$ 45	15
16	V	3	Housekeeping		S.W. Management Co.	100.00%	85	85	16
17	V	5	Utilities		S.W. Management Co.	100.00%	1,859	1,859	17
18	V	6	Maintenance		S.W. Management Co.	100.00%	528	528	18
19	V	17	Administrative	183,250	S.W. Management Co.	100.00%	55,355	(127,895)	19
20	V	19	Professional Services		S.W. Management Co.	100.00%	19,691	19,691	20
21	V	20	Dues, Fees, Subs & Promotions		S.W. Management Co.	100.00%	94	94	21
22	V	21	Clerical - Salaries		S.W. Management Co.	100.00%	65,199	65,199	22
23	V	21	Clerical & General Office Exp.		S.W. Management Co.	100.00%	5,523	5,523	23
24	V	24	Travel and Seminar		S.W. Management Co.	100.00%	78	78	24
25	V	25	Other Admin. Staff Transport.		S.W. Management Co.	100.00%	265	265	25
26	V	26	Insurance-Prop, Liab & Malp.		S.W. Management Co.	100.00%	1,258	1,258	26
27	V	27	Mgmt. Allocation of Benefits		S.W. Management Co.	100.00%	13,673	13,673	27
28	V	30	Depreciation		S.W. Management Co.	100.00%	3,549	3,549	28
29	V	32	Interest		S.W. Management Co.	100.00%	1,170	1,170	29
30	V	33	Real Estate Taxes		S.W. Management Co.	100.00%	3,909	3,909	30
31	V	35	Rent-Equipment & Vehicles		S.W. Management Co.	100.00%	1,391	1,391	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 183,250			$ 173,672	$ * (9,578)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Virgil Calvert Nursing and Rehabilitation Center # 0039651 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V		2	Food	$ 3,708	S & E Medical Supply Co.	100.00%	$ 5,510	$ 1,802	15
16	V		3	Housekeeping	4,210	S & E Medical Supply Co.	100.00%	4,210		16
17	V		10	Nursing and Medical Records	8,094	S & E Medical Supply Co.	100.00%	4,503	(3,591)	17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$ 16,012			$ 14,223	$ * (1,789)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Virgil Calvert Nursing and Rehabilitation C # 0039651 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week Hours	Percent	Compensation Included in Costs for this Reporting Period** Description	Amount	Schedule V. Line & Column Reference	
1	Sheldon Wolfe	President	Administrative	23.67%	See Schedule 7A	3	8.00	Salary	$ 55,355	L17,C7	1
2	Ronnie Klein	Shareholder	COO	5.5%	See Schedule 7B	4	10.00	Salary&Fees	66,231	17,3 & 21,7	2
3	Moshe Herman	CFO	Administrative	0.67%	See Schedule 7C	4.2	11.00	Salary	17,237	L21,C7	3
4											4
5											5
6			Note: All individuals work in excess of 40 hours per week.								6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 138,823		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Virgil Calvert Nursing and Rehabilitation Center
Provider #: 0039651
12/31/04
Sheldon Wolfe **Schedule 7A**

VII. Related Parties
C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors

	Weighted Average Hours Worked	Salary from S.W. Management	Fees from Facility	Total Compensation
Cahokia Nursing and Rehab	3	$ 55,355		$ 55,355
Caseyville Nursing and Rehab	3	55,355		55,355
Franklin Grove Nursing Center	3	55,355		55,355
Kenwood Healthcare Center	12	221,421		221,421
Oregon Healthcare Center	3	55,355		55,355
Shabbona Healthcare Center	4	73,807		73,807
Tower Hill Healthcare Center	4	73,807		73,807
Virgil Calvert Nursing and Rehab	3	55,355		55,355
St. Elizabeth Healthcare Center	1	18,452		18,452
Other	4	73,807		73,807
	40	$ 738,071		$ 738,071

SEE ACCOUNTANTS' COMPILATION REPORT

Virgil Calvert Nursing and Rehabilitation Center
Provider #: 0039651
12/31/04
Ronnie Klein **Schedule 7B**

VII. Related Parties
C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors

	Weighted Average Hours Worked	Salary from S.W. Management	Fees from Facility	Total Compensation
Cahokia Nursing and Rehab	3.5	$ 5,452	$ 60,000	$ 65,452
Caseyville Nursing and Rehab	3.5	5,452	60,000	65,452
Franklin Grove Nursing Center	5	7,788	90,000	97,788
Kenwood Healthcare Center	20	31,154	210,000	241,154
Oregon Healthcare Center	3.5	5,452	60,000	65,452
Shabbona Healthcare Center	0	-		-
Tower Hill Healthcare Center	0	-		-
Virgil Calvert Nursing and Rehab	4	6,231	60,000	66,231
St. Elizabeth Healthcare Center	0.5	779		779
Other	0	-		-
	40	$ 62,307	$ 540,000	$ 602,307

SEE ACCOUNTANTS' COMPILATION REPORT

Virgil Calvert Nursing and Rehabilitation Center
Provider #: 0039651
12/31/04
Moshe Herman **Schedule 7C**

VII. Related Parties
C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors

	Weighted Average Hours Worked	Salary from S.W. Management	Fees from Facility	Total Compensation
Cahokia Nursing and Rehab	4.2	$ 17,237		$ 17,237
Caseyville Nursing and Rehab	4.2	17,237		17,237
Franklin Grove Nursing Center	3.4	13,954		13,954
Kenwood Healthcare Center	8.8	36,115		36,115
Oregon Healthcare Center	2.8	11,491		11,491
Shabbona Healthcare Center	2.5	10,260		10,260
Tower Hill Healthcare Center	5.7	23,393		23,393
Virgil Calvert Nursing and Rehab	4.2	17,237		17,237
St. Elizabeth Healthcare Center	4.2	17,237		17,237
Other	0	-		-
	40	$ 164,160		$ 164,160

SEE ACCOUNTANTS' COMPILATION REPORT

s

Facility Name & ID Number Virgil Calvert Nursing and Rehabilitation Center # 0039651 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: SW Management Co.
Street Address: 7434 N. Skokie blvd.
City / State / Zip Code: Skokie, IL 60077
Phone Number: (847) 982-2300
Fax Number: (847) 982-2304

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	2	Food	Bed Days Available	527,040	9	$ 429	$	54,900	$ 45	1
2	3	Housekeeping	Bed Days Available	527,040	9	820		54,900	85	2
3	5	Utilities	Bed Days Available	527,040	9	17,851		54,900	1,859	3
4	6	Maintenance	Bed Days Available	527,040	9	5,071		54,900	528	4
5	19	Professional Services	Bed Days Available	527,040	9	189,030		54,900	19,691	5
6	20	Dues, Fees, Subs & Promotions	Bed Days Available	527,040	9	900		54,900	94	6
7	21	Clerical - Salaries	Bed Days Available	527,040	9	566,095	566,095	54,900	58,968	7
8	21	Clerical & General Office Exp.	Bed Days Available	527,040	9	53,022		54,900	5,523	8
9	24	Travel and Seminar	Bed Days Available	527,040	9	751		54,900	78	9
10	25	Other Admin. Staff Transport.	Bed Days Available	527,040	9	2,548		54,900	265	10
11	26	Insurance-Prop, Liab & Malp.	Bed Days Available	527,040	9	12,072		54,900	1,258	11
12	27	Mgmt. Allocation of Benefits	Bed Days Available	527,040	9	131,259		54,900	13,673	12
13	32	Interest	Bed Days Available	527,040	9	11,228		54,900	1,170	13
14	33	Real Estate Taxes	Bed Days Available	527,040	9	37,528		54,900	3,909	14
15	35	Rent-Equipment & Vehicles	Bed Days Available	527,040	9	13,358		54,900	1,391	15
16										16
17	17	Administrative - Salaries	Avg. Hours Worked	40	9	738,071	738,071	3	55,355	17
18	21	Clerical - Salaries	Avg. Hours Worked	40	7	62,307	62,307	4	6,231	18
19									3,549	19
20	30	Depreciation	Direct Cost							20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,842,340	$ 1,366,473		$ 173,672	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Virgil Calvert Nursing and Rehabilitation Center # 0039651 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: S & E Medical Supply Co.
Street Address: 3100 Commercial Ave.
City / State / Zip Code: Northbrook, IL 60062
Phone Number: (847) 982-9300
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	2	Food	Direct Cost			$	$		$ 5,510	1
2	3	Housekeeping	Direct Cost						4,210	2
3	10	Nursing and Medical Records	Direct Cost						4,503	3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 14,223	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Virgil Calvert Nursing and Rehabilitation Ce # 0039651 Report Period Beginning: 01/01/04 Ending: 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Heartland Bank		X	Mortgage	$23,524.00	11/27/01	$ 6,359,200	$ 6,203,241	12/01/2036	0.0635	$ 394,072	1
2												2
3												3
4												4
5												5
	Working Capital											
6	N/P-Stockholder	X		Working capital				436,212	Demand	Variable	19,287	6
7	Intercompany loan	X		Working capital				1,023,807	Demand	0.0600	49,402	7
8												8
9	TOTAL Facility Related				$23,524.00		$ 6,359,200	$ 7,663,260			$ 462,761	9
	B. Non-Facility Related*											
10								Amortization of mortgage costs			4,670	10
11								Interest income offset			(870)	11
12								SW Management Allocation - mortgage			1,170	12
13								Non-related interest			(68,689)	13
14	TOTAL Non-Facility Related						$	$			$ (63,719)	14
15	TOTALS (line 9+line14)						$ 6,359,200	$ 7,663,260			$ 399,042	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 29,819 Line # 36

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Virgil Calvert Nursing and Rehabilitation Center # 0039651 Report Period Beginning: 01/01/04 Ending: 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2003 report.		$ 161,382	1
	Management Co. allocation	3,909	
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2003	$ 162,337	2
3. Under or (over) accrual (line 2 minus line 1).		$ 4,864	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 168,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 172,864	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1999	91,676	8
	2000	112,153	9
	2001	130,316	10
	2002	153,697	11
	2003	162,337	12

2004 real estate tax accrual - $162,337 * 1.03 = $167,207
use = $168,000

SW Management allocation - $3,909

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Virgil Calvert Nursing and Rehabilitation Cente COUNTY St. Clair

FACILITY IDPH LICENSE NUMBER 0039651

CONTACT PERSON REGARDING THIS REPORT Sheldon Wolfe

TELEPHONE (847) 982-2300 FAX #: (847) 982-2304

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	02-21-0-209-021	Long-term care property	$ 162,337.00	$ 162,337.00
2.	10-28-412-049-0000	SW Management allocation	$ 38,970.00	$ 3,909.00
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 201,307.00	$ 166,246.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 200 tax bill which is normally paid during 2004

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Virgil Calvert Nursing and Rehabilitation Center # 0039651 Report Period Beginning: 01/01/04 Ending: 12/31/04

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ B. General Construction Type: Exterior _____ Frame _____ Number of Stories _____

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident care		2001	$ 400,000	1
2					2
3	TOTALS			$ 400,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Virgil Calvert Nursing and Rehabilitation Center # 0039651 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	150		2001		$ 4,801,297	$	15-40	$ 132,029	$ 132,029	$ 407,090	4
5											5
6	Mgmt. Co.		1995		45,086		39	1,288	1,288	12,437	6
7											7
8											8
	Improvement Type**										
9	Various			1994	30,236	830	20	1,512	682	15,409	9
10	Various			1995	25,180	559	20	1,260	701	12,419	10
11	Various			1996	5,688	244	20	284	40	2,462	11
12	Various			1997	4,115	106	20	206	100	1,579	12
13	Various			1998	4,092		20	205	205	1,603	13
14	Various			1999	27,640		20	1,429	1,429	7,648	14
15	Concrete Work			2000	3,181	82	20	159	77	716	15
16	Concrete Work			2000	5,030	129	20	252	123	1,132	16
17	Concrete Work			2000	5,195	133	20	260	127	1,170	17
18	Exhaust Fan			2000	3,820	440	20	191	(249)	1,114	18
19	Water Heater			2000	5,300	611	20	265	(346)	1,502	19
20	Carpeting			2000	5,400	662	20	270	(392)	1,440	20
21	Mechanical Room Volv			2000	1,315		20	66	66	264	21
22	Check Valve			2000	877		20	44	44	176	22
23	Plumbing			2000	1,024		20	51	51	204	23
24	100 Gal. Waterheater			2001	4,642		20	232	232	1,999	24
25	Steamer			2001	2,545	293	20	127	(166)	1,095	25
26	Concentrator			2001	2,703	311	7	386	75	1,415	26
27	Air Conditioner			2001	1,895	218	20	95	(123)	816	27
28	Fire Protection			2001	6,752	778	20	338	(440)	2,908	28
29	Air Conditioner			2001	8,313	958	20	416	(542)	3,580	29
30	Sprinkler Heads			2001	3,273	377	20	164	(213)	1,410	30
31	Blinds			2001	1,212	139	20	61	(78)	523	31
32	Sprinkler System Rep			2001	1,827		20	91	91	304	32
33	Heating Systems Repr			2001	1,269		20	63	63	195	33
34	Dining Room Wall			2002	11,663	299	10	1,166	867	3,110	34
35	Dining Room Wall			2002	8,020	206	10	802	596	2,139	35
36	Air Conditioners			2002	1,659	223	7	237	14	612	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number Virgil Calvert Nursing and Rehabilitation Center # 0039651 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Air Conditioners	2002	$ 2,185	$ 294	7	$ 312	$ 18	$ 806	37
38	Front Door	2003	9,860	253	20	493	240	986	38
39	Roof	2003	72,800	7,225	20	3,640	(3,585)	6,673	39
40	Gutters And Soffits	2003	24,221	2,301	20	1,211	(1,090)	2,018	40
41	Nursing Station	2003	2,901	650	20	145	(505)	254	41
42	Nursing Station	2003	13,285	2,976	20	664	(2,312)	1,162	42
43	Nursing Station	2003	12,188	1,950	20	609	(1,341)	863	43
44	Fire Sprinkler System	2003	2,075	332	20	104	(228)	165	44
45	Fire Suppression System	2003	2,030	325	20	102	(223)	152	45
46	100 Gl. Water Heater	2003	3,085	691	20	154	(537)	308	46
47	Resident Room Caseword/counters	2003	7,259	1,162	20	363	(799)	605	47
48	Pipe/Dry system	2004	2,472	55	20	62	7	62	48
49	Air Compressor	2004	2,766	56	20	69	13	69	49
50	Condensing unit and evaporator	2004	2,230	45	20	56	11	56	50
51	Concrete removal/new pipe	2004	6,111	124	20	153	29	153	51
52	A/C unit in Laundry System	2004	3,329	39	20	83	44	83	52
53	Sprinkler System	2004	2,056	20	20	51	31	51	53
54									54
55									55
56									56
57									57
58	SW Management Allocation - leasehold improvements	1995	4,810		20	240	240	2,662	58
59	SW Management Allocation - leasehold improvements	1996	840		20	42	42	360	59
60	SW Management Allocation - leasehold improvements	1997	1,210		20	61	61	603	60
61	SW Management Allocation - leasehold improvements	1998	833		20	42	42	281	61
62	SW Management Allocation - leasehold improvements	1999	2,313		20	115	115	588	62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 5,211,108	$ 26,096		$ 152,720	$ 126,624	$ 507,431	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Virgil Calvert Nursing and Rehabilitation Center # 0039651 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 951,100	$ 16,269	$ 130,407	$ 114,138	10	$ 467,130	71
72	Current Year Purchases	13,661	533	745	212	10	745	72
73	Fully Depreciated Assets							73
74	SW Management Allocation	11,644		1,157	1,157		9,918	74
75	TOTALS	$ 976,405	$ 16,802	$ 132,309	$ 115,507		$ 477,793	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	SW Management Allocation	Cadillac	2004	$ 6,038	$	$ 604	$ 604	5	$ 604	76
77										77
78										78
79										79
80	TOTALS			$ 6,038	$	$ 604	$ 604		$ 604	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 6,593,551	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 42,898	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 285,633	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 242,735	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 985,828	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Virgil Calvert Nursing and Rehabilitation Center # 0039651 Report Period Beginning: 01/01/04 Ending: 12/31/04

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ X NO

16. Rental Amount for movable equipment: $ 1,320 Description: Copier
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18	SW Management allocation			1,391	18
19					19
20					20
21	TOTAL		$	$ 1,391	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Virgil Calvert Nursing and Rehabilitation Center # 0039651 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   [ ] YES
   [X] NO

It is the policy of this facility to only hire certified nurses aides.

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	L10A, C3	hrs	$	8,887	$ 130,552	$	8,887	$ 130,552	1
2	Licensed Speech and Language Development Therapist	L10A, C3	hrs		1,761	54,667		1,761	54,667	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A, C3	hrs		8,107	109,199		8,107	109,199	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39, C2	# of prescrpts				60,443		60,443	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$	18,755	$ 294,418	$ 60,443	18,755	$ 354,861	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Virgil Calvert Nursing and Rehabilitation Center # 0039651 Report Period Beginning: 01/01/04 Ending: 12/31/04

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/04 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 39,186	$ 153,274	1
2	Cash-Patient Deposits	19,383	19,383	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	972,022	972,022	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	18,239	47,772	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Schedule 17A	85,331	292,989	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,134,161	$ 1,485,440	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		400,000	13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	206,121	5,211,108	15
16	Equipment, at Historical Cost	321,638	982,443	16
17	Accumulated Depreciation (book methods)	(322,660)	(985,828)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (sp See Schedule 17A		149,042	22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 205,099	$ 5,756,765	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,339,260	$ 7,242,205	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 45,316	$ 45,316	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	24,557	24,557	28
29	Short-Term Notes Payable	1,460,019	1,460,019	29
30	Accrued Salaries Payable	89,854	89,854	30
31	Accrued Taxes Payable (excluding real estate taxes)	10,992	10,992	31
32	Accrued Real Estate Taxes(Sch.IX-B)		168,000	32
33	Accrued Interest Payable	1,570	92,102	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Schedule 17A	77,513	77,513	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,709,821	$ 1,968,353	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		6,203,241	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 6,203,241	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,709,821	$ 8,171,594	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (370,561)	$ (929,389)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,339,260	$ 7,242,205	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Virgil Calvert Nursing and Rehabilitation Center
Provider #: 0039651
12/31/04

Schedule 17A

XV. BALANCE SHEET -

Other Current Assets (specify):	Operating	After Consolidation
Due from state	1,110	1,110
Other - escrow	0	234,186
Prior owner balance	58,417	58,417
Due/from Virgil Property LLC	25,804	(724)
Total Line 9 - Other Current Assets (specify):	**85,331**	**292,989**

Other Long-Term Assets (specify):	Operating	After Consolidation
Mortgage Costs	0	163,434
Accumulated Amortization	0	(14,392)
Total Line 22 - Other Long-Term Assets (specify	**0**	**149,042**

Other Current Liabilities (specify):	Operating	After Consolidation
Insurance Premiums Payable	1,271	1,271
Other Accrued expenses	76,242	76,242
Total Line 36 - Other Current Liabilities (specify	**77,513**	**77,513**

See Accountants' Compilation Report

Facility Name & ID Number Virgil Calvert Nursing and Rehabilitation Center # 0039651 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ (303,732)	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (303,732)	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(66,829)	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	( )	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (66,829)	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (370,561)	24	*

Operating Entity Only

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Virgil Calvert Nursing and Rehabilitation Center # 0039651 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,871,736	1
2	Discounts and Allowances for all Levels		2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,871,736	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	241,551	6
7	Oxygen	12,209	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 253,760	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,275	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,275	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,126,771	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	821,546	31
32	Health Care	1,575,924	32
33	General Administration	734,652	33
	B. Capital Expense		
34	Ownership	832,907	34
	C. Ancillary Expense		
35	Special Cost Centers	146,221	35
36	Provider Participation Fee	82,350	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,193,600	40
41	**Income before Income Taxes (line 30 minus line 40)****	(66,829)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (66,829)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.**
This entity is a cash basis taxpayer

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** **SEE ACCOUNTANTS' COMPILATION REPORT**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Virgil Calvert Nursing and Rehabilitation Center # 0039651 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,668	2,716	$ 80,243	$ 29.54	1
2	Assistant Director of Nursing	34	34	828	24.35	2
3	Registered Nurses	4,364	4,660	109,552	23.51	3
4	Licensed Practical Nurses	17,772	18,358	356,575	19.42	4
5	Nurse Aides & Orderlies	57,926	61,215	547,587	8.95	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,249	5,964	75,600	12.68	8
9	Activity Director					9
10	Activity Assistants	5,373	5,664	42,851	7.57	10
11	Social Service Workers	1,803	1,990	27,131	13.63	11
12	Dietician					12
13	Food Service Supervisor	1,901	2,133	29,688	13.92	13
14	Head Cook					14
15	Cook Helpers/Assistants	18,024	19,594	161,859	8.26	15
16	Dishwashers					16
17	Maintenance Workers	3,807	4,100	50,919	12.42	17
18	Housekeepers	11,625	12,619	101,773	8.07	18
19	Laundry	10,669	11,229	92,297	8.22	19
20	Administrator	1,953	2,040	59,735	29.28	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,388	7,066	96,355	13.64	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	149,556	159,382	$ 1,832,993 *	$ 11.50	34

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	96	$ 4,504	L1, C3	35
36	Medical Director	96	5,500	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	96	6,640	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	96	4,095	L10A, C3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	384	$ 20,739		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Virgil Calvert Nursing and Rehabilitation Center # 0039651 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Kathleen Crawford	Administrator	0	$ 59,735
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 59,735

B. Administrative - Other

Description	Amount
SW Management Fee	$ 60,000
Ronnie Klein - Administrative	60,000
SW Management - Home office	123,250
TOTAL (agree to Schedule V, line 17, col. 3)	$ 243,250
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Burroughs, Helper, Broom	Legal	$ 23,293
Winston & Strawn LLP	Legal	735
Personnel Planners, Inc	Unemployment Consultant	801
Frost, Ruttenberg & Rothblatt	Accounting	13,885
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 38,714

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 44,943
Unemployment Compensation Insurance	29,283
FICA Taxes	140,224
Employee Health Insurance	25,274
Employee Meals	2,529
Illinois Municipal Retirement Fund (IMRF)*	
Holiday expense	239
TOTAL (agree to Schedule V, line 22, col.8)	$ 242,492

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 2,500
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed 22)	254
Licenses	680
Illinois Council on Long Term Care	4,050
Inspections	800
Permits	150
SW Management Allocation	94
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 8,528

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	445
SW Management Allocation	78
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 523

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Virgil Calvert Nursing and Rehabilitation Center
Provider #: 0039651
12/31/04

Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

Total (agree to Schedule V, line 19, column 3)	38,714
Allocated from Virgil Calvert Property LLC:	
Accounting - Reznick Group, .P.C.	3,500
Allocated from SW Management:	
Legal	18,983
Accounting - Frost, Ruttenberg and Rothblatt	708
Total (agree to Schedule V, line 19, column 8)	61,905

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Virgil Calvert Nursing and Rehabilitation Center # 0039651 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5			N/A										
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Virgil Calvert Nursing and Rehabilitation Center **#** 0039651 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IL Council on Long Term Care - $4,050**

(3) Did the nursing home make political contributions or payments to a politica
action organization? **No** If YES, have these costs
been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the
end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **N/A** Line **N/A**

(7) Have all costs reported on this form been determined using accounting procedures
consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for
Schedule VII)? YES NO **X** If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over
o

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department
of Public Aid during this cost report period. $ **82,350**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V
for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to
the Department of Public Aid, in addition to the daily rate, been properly classifiec
in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for
the patient census listed on page 2, Section B? **No** For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach
a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V. $ **2,529** Has any meal income been offset against
related costs? **N/A** Indicate the amount. $ **n/a**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for
residents? **No** If YES, please indicate the amount of income earned from such a
program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained.**
e. Are all vehicles stored at the nursing home during the night and all other
times when not in use? **No**
f. Has the cost for commuting or other personal use of autos been adjusted
out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such
transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A** The instructions for the
cost report require that a copy of this audit be included with the cost report. Has this copy
been attached? **N/A** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted ou
out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services
performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

	Salaries	Supplies	Other	Total	Reclass-ifications	Reclassified Total	Adjustments	Adjusted Total
1. Dietary	191,547	10,648	4,504	206,699	0	206,699	0	206,699
2. Food Purchase	0	163,238	0	163,238	0	163,238	-682	162,556
3. Housekeeping	101,773	39,603	0	141,376	0	141,376	85	141,461
4. Laundry	92,297	16,418	0	108,715	0	108,715	0	108,715
5. Heat and Other Utilities	0	0	99,423	99,423	0	99,423	1,859	101,282
6. Maintenance	50,919	42,069	9,107	102,095	0	102,095	528	102,623
7. Other (specify)*	0	0	0	0	0	0	0	0
8. Total General Services	436,536	271,976	113,034	821,546	0	821,546	1,790	823,336
9. Medical Director	0	0	5,500	5,500	0	5,500	0	5,500
10. Nursing & Medical Records	1,170,385	22,429	6,640	1,199,454	0	1,199,454	-3,591	1,195,863
10a. Therapy	0	0	298,513	298,513	0	298,513	0	298,513
11. Activities	42,851	2,475	0	45,326	0	45,326	0	45,326
12. Social Services	27,131	0	0	27,131	0	27,131	0	27,131
13. Nurse Aide Training	0	0	0	0	0	0	0	0
14. Program Transportation	0	0	0	0	0	0	0	0
15. Other (specify)*	0	0	0	0	0	0	0	0
16. Total Health Care & Programs	1,240,367	24,904	310,653	1,575,924	0	1,575,924	-3,591	1,572,333
17. Administrative	59,735	0	243,250	302,985	0	302,985	-127,895	175,090
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	38,714	38,714	0	38,714	23,191	61,905
20. Fees, Subscriptions & Promotion	0	0	8,434	8,434	0	8,434	94	8,528
21. Clerical & General Office	96,355	0	26,081	122,436	0	122,436	70,295	192,731
22. Employee Benefits & Payroll	0	0	239,963	239,963	0	239,963	2,529	242,492
23. Inservice Training & Education	0	0	0	0	0	0	0	0
24. Travel and Seminar	0	0	445	445	0	445	78	523
25. Other Admin. Staff Trans	0	0	5,906	5,906	0	5,906	265	6,171
26. Insurance-Prop.Liab.Malpractice	0	0	15,769	15,769	0	15,769	1,258	17,027
27. Other (specify)*	0	0	0	0	0	0	13,673	13,673
28. Total General Adminis	156,090	0	578,562	734,652	0	734,652	-16,512	718,140
29. Total General Administrative	1,832,993	296,880	1,002,249	3,132,122	0	3,132,122	-18,313	3,113,809
30. Depreciation	0	0	42,898	42,898	0	42,898	242,735	285,633
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0
32. Interest	0	0	68,689	68,689	0	68,689	330,353	399,042
33. Real Estate	0	0	0	0	0	0	172,864	172,864
34. Rent - Facility & Grounds	0	0	720,000	720,000	0	720,000	-720,000	0
35. Rent - Equipment & Vehicles	0	0	1,320	1,320	0	1,320	1,391	2,711
36. Other (specify):*	0	0	0	0	0	0	29,819	29,819
37. Total Ownership	0	0	832,907	832,907	0	832,907	57,162	890,069
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	60,443	0	60,443	0	60,443	0	60,443
40. Barber and Beauty Shop	0	0	0	0	0	0	0	0
41. Coffee and Gift Shops	0	0	0	0	0	0	0	0
42	0	0	82,350	82,350	0	82,350	0	82,350
43. Other (specify):*	0	0	85,778	85,778	0	85,778	-85,778	0
44. Total Special Cost Ce	0	60,443	168,128	228,571	0	228,571	-85,778	142,793
45. Grand Total	1,832,993	357,323	2,003,284	4,193,600	0	4,193,600	-46,929	4,146,671

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	3,871,736
2. Discounts and Allowances for all Levels	0
Subtotal - Inpatient Care	3,871,736
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	241,551
7. Oxygen	12,209
Subtotal - Anciliary Revenue	253,760
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	0
14. Non-Patient Meals	0
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	0
18. Sale of Supplies to Non-Patients	0
19. Laboratory	0
20. Radiologyand X-Ray	0
21. Other Medical Services	0
22. Laundry	0
Subtotal - Other Operating Revenue	-
24. Contributions	0
25. Interest and Other Investments Income	1,275
Subtotal - Non-Operating Revenue	1,275
27. Other Revenue (specify):	0
28. Other Revenue (specify):	0
Subtotal - Other Revenue	-
30. Total Revenue	4,126,771
31. General Services	821,546
32. Health Care	1,575,924
33. General Administration	734,652
34. Ownership	832,907
35. Special Cost Centers	146,221
35. Provider Participation Fee	82,350
37. Other	0
40. Total Expenses	4,193,600
41. Income Before Income Taxes	-66,829
42. Income Taxes	0
43. Net Income or Loss for the Year	-66,829

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	39,186	153,274
2. Cash - Patient Deposits	19,383	19,383
3. Accounts & Notes Recievable	972,022	972,022
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	18,239	47,772
7. Other Prepaid Expenses	0	0
8. Accounts Receivable-Owner/Related Party	0	0
9. Other (specify):	85,331	292,989
10. Total current assets	1,134,161	1,485,440
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	0	400,000
14. Buildings, at Historical Cost	0	0
15. Leasehold Improvements, Historical Cost	206,121	5,211,108
16. Equipment, at Historical Cost	321,638	982,443
17. Accumulated Depreciation (book methods)	-322,660	-985,828
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	0	149,042
23. other (specify):	0	0
24. Total Long-Term Assets	205,099	5,756,765
25. Total Assets	1,339,260	7,242,205
CURRENT LIABILITIES		
26. Accounts Payable	45,316	45,316
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	24,557	24,557
29. Short-Term Notes Payable	1,460,019	1,460,019
30. Accrued Salaries Payable	89,854	89,854
31. Accrued Taxes Payable	10,992	10,992
32. Accrued Real Estate Taxes	0	168,000
33. Accrued Interest Payable	1,571	92,102
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	77,513	77,513
37. Other Current Liabilities (specify):	0	0
38. Total Current Liabilities	1,709,822	1,968,353
LONG TERM LIABILITES		
39.Long-Term Notes Payable	0	0
40.Mortgage Payable	0	6,203,241
41.Bonds Payable	0	0
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	0	0
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	0	6,203,241
46.Total Liabilities	1,709,822	8,171,594
47.Total Equity	-370,562	-929,389
48.Total Liabilities and Equity	1,339,260	7,242,205